## Malika Abdul-Basir

**From:** John Vanlente <jvanlente@wmttlc.com>
**Sent:** Tuesday, January 31, 2012 7:18 PM
**To:** Malika Abdul-Basir
**Subject:** case study

Yesterday 01/30/2012, I sat with a substance dependent person with a history of using substances to get to sleep. He reported a history of mood swings, racing thoughts, verbal rages that he could not get anyone at the local community mental health to help him with. When he again came to the office with little sleep, pressured speech arguing with his significant other on the phone I assisted as he made a call to Central Access at Community Mental Health. I initiated the call to the person who would not take a referral from me or any of my assessments of this person's mood disorder; she wanted to have him call. I put him on the line immediately and he did a good job of detailing his symptoms. She changed the conversation to a financial screening on the phone and then was argumentative with him since he told her that not all parolees were under the MPRI process; she rebutted that her supervisor told her they were...He was about to start expletives but responded to my caution to, "just get an appointment for assessment".

The point is: if this is how hard it is to get a mentally ill substance abuser treatment for mood swings how much more difficult will it be to get them substance abuse treatment under the umbrella of an inaccessible mental health system. They will take the definitions, do the studies, add a million dollars in training fees, build a better information system, buy some more cars, add on to the buildings and we will end up with the clients who will get kicked out do to inability to get through the gauntlet of rejection they have to face to actually get treatment. Please please please do the math....you cannot add more money to a system with high high high non direct overheads and expect any treatment to occur. The fact that they are not succeeding with the chronic and acute mentally ill is due to their current failure to address the substance abuse factors. Why would we extend their range further. In my town we are working from 4 to 5 on relapse prevention on Friday Nights while our mental health associates have already reported to "happy hour". If they cannot get 80 % of their clinical staff to pass random urinalysis they should not get a dime for substance abuse treatment.

I have spent 42 years primarily in the management of inpatient psychiatric units in the role of integrating co occurring treatment protocols. Due to the limited supply of mental health treatment we in the substance treatment arena are now assuming those clients as well.

John Van Lente LMSW cell 231-750-7668